



THE AFFORDABLE CARE ACT
**AFFORDING TWO-GENERATION
APPROACHES TO HEALTH**



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* List of participants on pg. 47.

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LEAD ORGANIZATIONS

The **Aspen Institute** is an educational and policy studies organization based in Washington, DC. Its mission is to foster leadership based on enduring values and to provide a nonpartisan venue for dealing with critical issues. The Institute has campuses in Aspen, Colorado, and on the Wye River on Maryland's Eastern Shore. It also maintains offices in New York City and has an international network of partners.

www.aspeninstitute.org

Ascend at the Aspen Institute is the national hub for breakthrough ideas and collaborations that move children and their parents toward educational success and economic security. Ascend takes a two-generation approach to our work – focusing on children and their parents together – and we bring a gender and racial equity lens to our analysis. We believe that education, economic supports, social capital, and health and well-being are the core elements that create an intergenerational cycle of opportunity. As a new model of social innovation, we are building a brain trust of diverse leaders through a national fellowship program and learning network; elevating and investing in two-generation programs, policies, and community solutions; and sparking and expanding a conversation to ensure the perspectives and resilience of families inform program design and policy development.

<http://ascend.aspeninstitute.org>

The Aspen Institute's **Health, Medicine and Society Program** is a venue for academic, government and industry leaders to explore critical issues in health care and health policy and how they may affect individual health and that of families, communities, nations and the world. By convening bipartisan, multi-disciplinary forums, the program facilitates the exchange of knowledge and insights among decision-makers and helps to forge networks and other collaborations with the ultimate goal of improving human health.

www.aspeninstitute.org/policy-work/health-medicine-society

The **National Academy for State Health Policy** (NASHP) is an independent academy of state health policymakers. We are dedicated to helping states achieve excellence in health policy and practice. A non-profit and non-partisan organization, NASHP provides a forum for constructive work across branches and agencies of state government on critical health issues.

www.nashp.org

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FOREWORD

The Affordable Care Act (ACA) offers transformative opportunities to produce better health for low-income children and families. By highlighting the connection between a vital health delivery system and economic stability and security, the ACA can be a bridge to a more comprehensive strategy around breaking the intergenerational cycle of poverty. This is a historic time in the history of U.S. health care: There is great opportunity to eradicate health inequities; provide comprehensive, preventive measures to children and families; and actualize the vision of a health care system that equally weighs the social determinants of health for low-income families. But we will need fresh thinking and practical recommendations if we are to translate this landmark opportunity into innovative approaches that can help parents and children together attain quality, affordable health care.

The Aspen Institute's mission is to foster leadership based on enduring values and to provide a nonpartisan venue for dealing with critical issues; this mission drives our current efforts. Two of the Institute's programs — Ascend at the Aspen Institute and the Health, Medicine and Society program — have recently received urgent requests to provide leadership and bring together high-level

stakeholders across many sectors to explore “shovel-ready” state and local opportunities to help vulnerable families gain better access to quality health care. In particular, programs, practitioners, and communities committed to implementing two-generation approaches that provide opportunities for and meet the needs of vulnerable children and their parents together want to understand how the provisions of the ACA might provide new ways to further their work.

To answer this call, The Aspen Institute has partnered with the National Academy for State Health Policy to explore the potential of two-generation approaches within the ACA that could have a significant positive impact on low-income families. The result of this collaboration is this publication — the first of its kind to look at the evolving U.S. health care system through a two-generation lens. Never before has the potential for change been so great, and never before has the opportunity to leverage health and well-being in a family's path to permanent economic security been so promising. Highlights of two-generation policies that can emerge from this new policy environment and link family economic security to family health and well-being include:

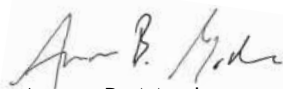
- Expanding Medicaid coverage by identifying and enrolling individuals who are eligible for

Medicaid to promote the health and well-being of low-income parents and children.

- Increasing efforts to support additional focus on education and employment opportunities for parents in home visiting programs, while supporting school readiness and health and well-being in children. Funding streams, such as Maternal, Infant, and Early Childhood Home Visiting, require that programs demonstrate not just improved child outcomes (e.g., school readiness) but also adult outcomes (e.g., economic self-sufficiency).*
- Maximizing opportunities for diagnosis, screening and treatment of mental health for both parents and children using the new coverage of preventive services such as adult depression screenings and child behavioral assessments.
- Promoting linkages between health care and human services systems, using community health teams, a focused use of resources in geographic areas with high costs and high need families, and other approaches.

pathways to employment for low-income parents, while offering quality early learning to their children at the same time. Ideas like these are at the vanguard of this new policy landscape. But there is more that can be done.

We invite leaders and stakeholders to fully explore and integrate two-generation approaches into work around health and well-being. We believe the conversation will invite new partnerships and spur new approaches to create not just healthier communities, but increased economic opportunity for all.



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The ACA offers new possibilities for helping families two generations at a time. Oregon has used the ACA as a springboard for innovation, linking health care transformation to school readiness. Communities are tapping the workforce expansion provisions of the ACA to offer new

*Patient Protection and Affordable Care Act (Enrolled Bill [Final as Passed Both House and Senate] - ENR). Bill Text 111th Congress (2009-2010) H.R. 3590.ENR. Retrieved from <http://thomas.loc.gov/cgi-bin/query/z?c111:H.R.3590.enr>:

EXECUTIVE SUMMARY

The Affordable Care Act (ACA), signed into law by President Barack Obama on March 23, 2010, represents the largest transformation of American health policy in more than a generation. The law redefines how health insurance functions, significantly expands health insurance coverage, and accelerates changes already underway in how health care services are organized and delivered to patients. This transformation creates new opportunities for improving the health and well-being of vulnerable children and their parents. Ascend at the Aspen Institute promotes a two-generation approach to creating opportunity for vulnerable families. In Ascend's two-generation framework, health is an element of family and child well-being in its own right and a supportive factor in achieving the educational, economic, and social assets families need to thrive. This paper describes the changes in health care effected by the ACA and explores the unfinished business of developing a health care system that supports two-generation approaches.

One in five American adults under age 65 was without health insurance in 2012.¹ The uninsurance rate was an astonishing 39 percent for adults with incomes below twice the federal poverty level (FPL).^{2,3} Rates of uninsurance

are particularly high for Hispanic adults; 41 percent go without health insurance.⁴ The nation cut the number of uninsured children in half with the enactment of the Children's Health Insurance Program (CHIP) in 1997, but 7 million remain uninsured.⁵

The ACA expands and simplifies Medicaid eligibility for adults with incomes up to 138 percent of FPL.* It provides tax credits to purchase health insurance on an insurance exchange for adults with incomes up to 400 percent of FPL. The Act prohibits insurers from refusing to cover individuals with pre-existing health conditions, mandating that insurers offer coverage to all children and adults regardless of their health status. Almost all health plans must now cover a set of essential benefits that includes hospital and physician services, prescription drugs, maternity care, mental health and substance abuse services, and preventive services.

The ACA has already yielded significant increases in health insurance coverage and has

**The Medicaid funding stream is the largest source of health coverage in the United States for low-income families. Medicaid is a federally authorized program funded with both federal and state dollars. States have flexibility in determining who is eligible for the program. Under the Affordable Care Act, states were required to expand those qualified for coverage to all people under age 65 with income up to 133 percent of the federal poverty level, although a subsequent Supreme Court ruling gave states the option of declining this coverage. The funding for this expansion of eligibility is initially provided entirely by the federal government. About half the states currently have a Medicaid program that includes this expanded definition of who qualifies for coverage; this issue is discussed more thoroughly later in the paper.*

moved the health care system toward much better accountability. But work remains, and that work has implications for two-generation approaches. This paper is divided into two sections: Section one focuses on health insurance coverage under the ACA, and section two focuses on the organization of the health care system. Both sections are framed around the overall goal of family well-being. They address opportunities for two-generation approaches and point out “unfinished business” — those issues and areas that need further focus and improvement to maximize opportunities for family health and well-being.

With regard to improvements in health insurance coverage, there are three areas of unfinished business that demand further attention and action:

- **Extending Medicaid Eligibility.** Identify and enroll individuals who are eligible for Medicaid. With its critical role in promoting the health and well-being of low-income parents and children, expanding Medicaid coverage should be a central focus of those pursuing the two-generation approach.
- **Assuring Continuous Enrollment.** Streamline enrollment processes and procedures for all avenues of health care coverage. During its first open enrollment period, the ACA is estimated to have generated net gains in health insurance coverage for some 9.3 million people.⁶ To secure and build upon these gains, the nation must streamline the enrollment process for coverage through Medicaid, CHIP, or health insurance exchanges;

identify and enroll those who are uninsured in the appropriate program; and keep those who enroll covered as their life circumstances change and they face disruptions in insurance coverage.

- **Minimizing Financial Burdens.** Ensure adequacy of the ACA premium subsidies. Despite the availability of subsidies to help cover the costs of insurance premiums, health insurance and health care remain costly. Continued work is necessary to ensure that these subsidies are sufficient to provide access to services.

Despite having the most costly health care system in the world, Americans' lives are shorter and less healthy than those of people in many other industrialized countries.⁷ Our relatively poor health reaches across income categories, although the burden of our underperforming health system falls disproportionately on those who are most vulnerable.

The ACA dramatically accelerates fundamental shifts in how health care services are delivered and financed. The ACA contains a range of initiatives designed to pilot, evaluate, and scale innovative approaches to payment and delivery that move the health care system from piece-by-piece reimbursement toward financing models that reward value-based, whole-person care.

With regard to improvements in the organization of the health care system, three areas demand further attention and action:

- **Advancing integration within the system.** Develop and promote

mechanisms designed to better integrate physical and mental health services. To operate more efficiently and effectively, the health care system must become more integrated, building upon progress made in developing patient-centered medical homes, creating new models such as Accountable Care Organizations, and retraining and redefining the health care workforce.

- **Coordinating human services and medical services.** Support efforts targeted on a “whole person” or family-oriented approach to health and well-being. The health care system must continue to evolve to take into account the social needs as well as medical needs of individuals and their families. Initiatives should be advanced that create formal linkages between the health care system and the human services system through community health teams and integrated eligibility systems and with a focus of resources on high-need families and geographic areas with high costs (i.e., “hotspotting”).
- **Promoting equity through accountability of care.** Include health equity as an element of accountable care. The drive toward accountable systems of care holds great promise for the sort of integration and coordination most important for vulnerable families. Work remains to ensure these systems are designed to help eliminate health disparities and that pressure to create short-term savings does not divert attention from long-term investments in family well-being.

The ACA has already significantly increased health insurance coverage and has moved the health care system toward greater accountability. A better functioning health system that is more fully integrated in and reflective of a variety of social determinants important for child and parent well-being and family economic success is necessary to achieve a two-generation approach to creating opportunity for vulnerable families. The ACA moves the nation forward in achieving this goal, but much work remains.

INTRODUCTION

The Affordable Care Act, signed into law by President Barack Obama on March 23, 2010, represents the largest transformation of American health policy in more than a generation. The law redefines how health insurance functions, significantly expands health insurance coverage, and accelerates changes already underway in how health care services are organized and delivered to patients. This transformation creates new opportunities for improving the health and well-being of vulnerable children and their parents, and enables more innovative two-generation approaches in the system of care and delivery.

Ascend at the Aspen Institute is dedicated to promoting a two-generation approach to creating opportunity for vulnerable families. Ascend draws on a history of efforts to address the needs of both children and parents while capitalizing on the implications of what science has demonstrated: The development of children and parents is inextricably linked.⁸ Parents gain motivation to succeed from their children — and

vice versa — in a way that is mutually reinforcing.⁹

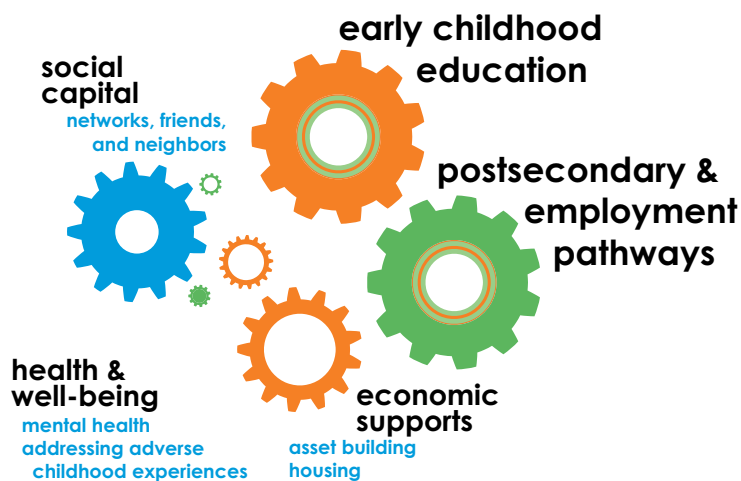
The premise of a two-generation strategy — based on evidence from the field — is that supporting families with programs, policies, and community initiatives that serve children and parents together will generate results far greater than the sum of their parts. This perspective is consistent with how the health care system functions, since parental health is part of family well-being, and parents make critical decisions that affect their children's health and well-being.

Families may be vulnerable for a variety of reasons: low income, exposure to violence and other significant adverse childhood experiences, poor academic achievement, limited work opportunity, and limited affordable housing. Poor health is also a source of vulnerability, and policies that improve the health of families can open up new opportunities for their success.

This paper is designed to provide those interested in the role of health in promoting opportunity for vulnerable families with the information necessary to pursue a two-generation approach to health and well-being. This paper is divided into two sections.

The first section focuses on changes in health care coverage effected by the ACA and explores the unfinished business of developing coverage and enrollment systems that support two-generation approaches. The second section addresses changes in the organization and delivery of health care services and identifies areas of opportunity within the ACA to support vulnerable families.

Ascend Two-Generation Framework: Core Components



	Pre-ACA	Affordable Care Act	Unfinished Business
Coverage	<ul style="list-style-type: none"> • Strong kids' coverage • Some parent coverage • Weak adult coverage • Coverage gaps preventing access to care 	<ul style="list-style-type: none"> • Modest changes to kids' coverage • Expanded parent and adult coverage • More comprehensive benefits for both kids and adults 	<ul style="list-style-type: none"> • 24 states electing not to undertake the Medicaid expansion • Coverage for whole families a challenge • Challenges in continuity of coverage • High costs for family coverage
Delivery	<ul style="list-style-type: none"> • Fragmented care delivery • Payment rewarding quantity of services rather than outcomes or quality of care 	<ul style="list-style-type: none"> • Support for payment and coordinated care models that support integration and accountability, including Health Homes, episode of care bundling, State Innovation Models Initiative 	<ul style="list-style-type: none"> • Coordination among physical, mental, and oral health • Perfecting and expanding integration and payment models • Health care workforce • Health equity and addressing social determinants of health

THE ASCEND TWO-GENERATION FRAMEWORK

The Ascend two-generation framework identifies early childhood education, postsecondary and employment pathways, economic supports, social capital, and health and well-being as the core components that create an intergenerational cycle of opportunity. Good health and well-being is one of the core components of the Ascend framework.¹⁰ There is a well-documented correlation between poor health and poor family finances — with the causation believed to go in both directions.¹¹ Educational achievement is correlated with longer lifespans, improved adult health outcomes, and health-promoting behaviors.^{12,13,14} Good health also promotes student achievement — better physical health and health behaviors are associated with higher scores on standardized

tests.¹⁵ Good mental health and strong parental efficacy are core elements of social capital.

Health is not just a supportive factor in the two-generation framework; good health is a cornerstone of family and child well-being in its own right. The World Health Organization's definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" embraces this view.¹⁶ A well-functioning health care system that supports the health and well-being of vulnerable parents and children is necessary for all families to thrive.

PART I:
**HEALTH INSURANCE THAT
PROMOTES FAMILY WELL-
BEING: COVERAGE UNDER
THE ACA**

Having health insurance is a critical element of whole family well-being. Health insurance provides financial protection and peace of mind, facilitates access to needed health care services, and improves health while reducing disability and premature death.¹⁷ This section describes the importance of health insurance, including mental health coverage, for adults and children; explains how the ACA expanded access to health insurance; and describes the work that remains to assure access to health care for all vulnerable families.

Unexpected medical bills for even one uninsured family member can jeopardize an entire family's economic security. In 2008, over 40 percent of non-elderly adults who were uninsured at some point during the year reported being unable to pay for basic necessities, including food, heat, or rent, because of medical debt.¹⁸ The Institute of Medicine's Committee on the Consequences of Uninsurance reported that more than one-fourth of uninsured families living in poverty had out-of-pocket health expenses

exceeding 5 percent of family income in 2002.¹⁹ Financial strain due to poor health or large health-related expenses can be a barrier to families building the assets they need to succeed.

Lack of coverage is both a financial risk and a health risk. Uninsured adults are more likely than those with insurance to report being in fair or poor health and to go without needed care due to cost.²⁰ They are less likely to receive recommended preventive care and more likely to be diagnosed at later stages of disease.²¹ Parents in poor health experience difficulty securing and maintaining full-time employment and may struggle to provide financial and psychosocial support for their children.²²

Health insurance coverage is important at all stages of life but is of particular importance in the perinatal period. Uninsured women receive less prenatal care and fewer perinatal services and are likelier to have poor outcomes in pregnancy and delivery than insured women.²³ Preconception coverage improves overall adult health, with positive effects on future births and children's health over the lifespan. Preconception health coverage also promotes access to family planning services, potentially lowering unwanted pregnancy rates and expanding time between births.

Coverage of parents and their children is inextricably linked. Nearly all children of insured parents are themselves insured. These children are more likely than the children of uninsured parents to use health

care services appropriately.²⁴ By contrast, children of low-income, uninsured parents are three times more likely to be uninsured themselves and more likely to experience difficulties accessing needed care than children with insured parents.²⁵ Parents' own health care utilization is strongly related to their children's utilization; insured children with uninsured parents are less likely to have seen a physician in the past year.²⁶

Uninsured children use medical and dental care less often than insured children.²⁷ Uninsured children are less likely than insured children to have a regular source of care and receive recommended preventive services, including early treatment for developmental issues.^{28, 29} People without health insurance often receive care late in the onset of health problems, or forego care entirely, placing them at higher risk of hospitalization for conditions that could be managed in a doctor's office.³⁰ Lack of early diagnosis and intervention for many childhood conditions, including asthma, autism, and attention deficit and hyperactivity disorder, can limit children's functioning and opportunities over the lifespan. Diagnoses of serious and life threatening conditions may also be missed.

Unmet mental health needs are a particular burden for vulnerable families. Parents' mental health and emotional well-being can have profound effects on children's development. Adverse childhood experiences, including household dysfunction, abuse, and neglect, are linked to poorer adult health, including the development of

physical and mental health conditions and substance abuse disorders.³¹ Children of parents with mental illness may also be more likely to experience learning and communication difficulties.³² One in 10 mothers suffers from maternal depression, which, in addition to afflicting the mother, impairs caretaking and can hinder children's healthy development.³³

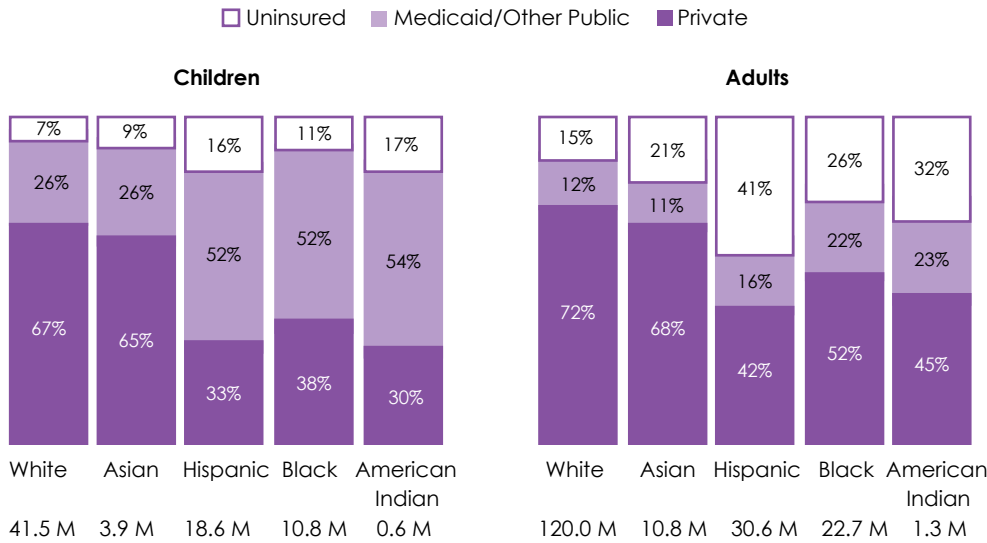
HEALTH INSURANCE BEFORE THE ACA

The Affordable Care Act was the culmination of efforts over many decades to provide health security to all Americans. In the absence of a comprehensive national strategy, the number of Americans without coverage has grown steadily. Public insurance programs have grown to offset declines in private, employer-sponsored coverage. Behind these broad trends are stark disparities in access to health insurance based on income, family composition, and race and ethnicity.

One in five American adults under age 65 was without health insurance in 2012.³⁴ The uninsurance rate was an astonishing 39 percent for adults with incomes below twice the FPL.^{35, 36} Rates of uninsurance are particularly high for Hispanic adults; 41 percent go without health insurance.³⁷ For many Americans, uninsurance is the norm — nearly half of currently uninsured

In 2008, over 40 percent of non-elderly adults who were uninsured at some point during the year reported being unable to pay for basic necessities, including food, heat, or rent, because of medical debt.

Health Insurance Coverage by Age and Race/Ethnicity, 2011



Asian group includes Pacific Islanders. American Indian group includes Aleutian Eskimos. Two or more races excluded. Data may not total 100% due to rounding. Source: Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of 2012 Annual Social and Economic Supplement to the Current Population Survey. Adapted and reprinted with permission from the Kaiser Family Foundation.



in 1965, the program was linked to cash assistance and covered primarily very low-income single mothers, their children, and the poor, aged, blind, and disabled. Before the ACA, family income eligibility thresholds were at the discretion of states and varied by employment status, with a median eligibility level across states of 61 percent of FPL for working parents and 37 percent of FPL for jobless parents.⁴² That is, in the majority of states, parents in a family of four with total earnings of \$15,000 would earn too much to be eligible for health insurance through Medicaid.

adults have not had coverage in the past five years, while nearly a fifth have never been covered.³⁸ More than 60 percent of the uninsured have at least one full-time worker in the family.³⁹

Parents are somewhat more likely to have health insurance than other adults.⁴⁰ Still, the uninsurance rate for parents is just under one in five. The overall uninsurance rate for children is 7 percent, but it is twice that for children in households with earnings below 200 percent of FPL.⁴¹

These figures reflect the limited scope of the public health insurance programs for low-wage workers and families before the ACA. When Medicaid was created

Adults without dependent children have never been eligible for Medicaid unless the state receives special permission from the federal government, which only nine states had in 2013.⁴³ Historically, this population has had the highest rates of uninsurance (23 percent uninsured prior to ACA) due to relatively low wages and ineligibility for public insurance programs.

Excluding adults without dependent children from coverage has significant negative consequences for vulnerable families. This group includes a large number of married and single young adults who will ultimately have children. Assuring that their health needs are met before they have children improves parental physical and mental health, yields better pregnancy outcomes, and has positive future consequences for them and their

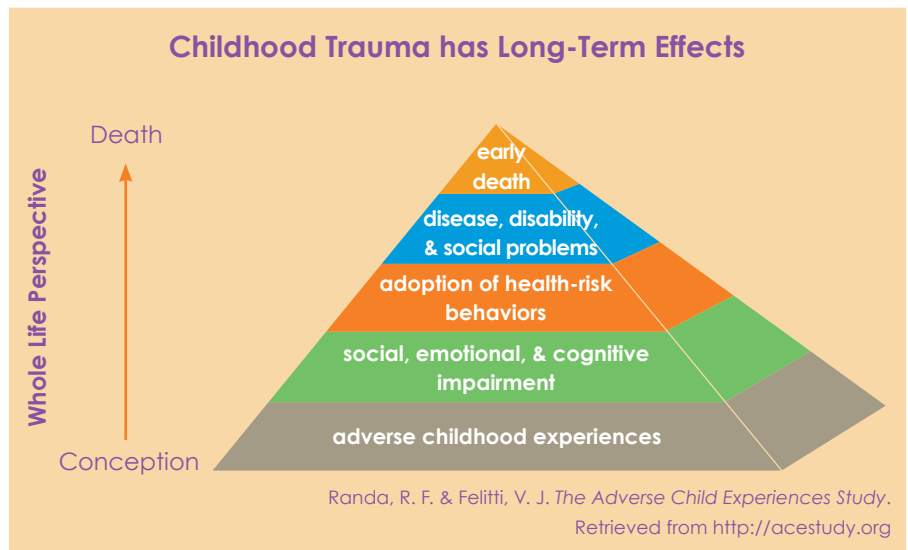
More than 60 percent of the uninsured have at least one full-time worker in the family.

children. The excluded group also includes parents without custody of their children, but who may have significant involvement in their children's lives. Poor health and financial strain — two potential consequences of uninsurance — are barriers to families achieving success.

For decades, children's eligibility for public health insurance programs has been more expansive than adults' eligibility. Leading up to the ACA, all children living in poverty were eligible for Medicaid, and children under age 6 were eligible up to 133 percent of FPL or higher, at state discretion. Enacted in 1997, the Children's Health Insurance Program (CHIP) gave states strong incentives to expand coverage options to children up to and above 200 percent of FPL, cutting the uninsured rate for children in half.⁴⁴

Public health insurance programs are of particular importance to families of color.⁴⁵ Overall, nearly six in 10 Medicaid enrollees are people of color. More than half of Black and Hispanic children are covered by the Medicaid or CHIP programs — nearly double the rate of White non-Hispanic children.⁴⁶ Twenty-two and 16 percent of Black and Hispanic adults, respectively, are covered by Medicaid. While around 19 percent of all nonelderly Asians are covered by public insurance, public coverage rates are much higher for certain Asian subgroups: 28 percent of Native Hawaiians and Pacific Islanders, 43 percent of Hmong, and 37 percent of Bangladeshis have public health insurance coverage.⁴⁷

Public health insurance programs have certain features designed



Populations at risk of being excluded from coverage

- Parents without custody of their children (or non-custodial parents)
- New mothers (whose Medicaid eligibility can be disrupted)
- Adults leaving incarceration

to meet the needs of the very low-income people they serve. Federal law mandates that state Medicaid programs cover a comprehensive set of services with only nominal copayments and, for most enrollees, no premiums. Under Medicaid's Early and Periodic Screening, Diagnosis and Treatment benefit, states must provide children under age 21 with all medically necessary services, such as developmental screenings, lead toxicity screenings, physical and occupational therapies, and dental care. Families with children enrolled in CHIP receive a somewhat narrower benefit package and can be charged premiums, but the total they pay in premiums, copayments, and deductibles is capped at 5 percent of family income.

Before enactment of the ACA, private health insurance was highly variable in the services it

covered and the costs patients incurred when they used services. Larger employers typically offered comprehensive coverage; smaller firms were more likely to offer limited benefits, if they provided coverage at all. Policies sold directly to individuals were often unavailable to people with health conditions. When available, that coverage could carry a very high premium, exclude certain conditions or services, and have extremely high deductibles. Before the ACA, nearly 20 percent of plans sold in the individual health insurance market provided no mental health coverage.

If fully implemented, the ACA's Medicaid expansion would provide new coverage to 4.6 million reproductive-age women, 2.7 million parents, 2.9 million Hispanic adults, and 2.8 million Black adults.

The shortcomings of commercial health insurance leave many at financial risk even if they have insurance. The Commonwealth Fund reported that nearly 57 million low-income families were underinsured in 2012 — meaning they were at high risk of economic ruin in the face of a single health episode.⁴⁸ Like the uninsured, the underinsured are likely to forego needed care because of costs.⁴⁹ Even if they recover from an adverse health event, their family's financial well-being may be permanently damaged.

CHANGES UNDER THE ACA

The ACA created new pathways to coverage for adults, modified the sources of coverage for children, and changed how health insurance coverage and benefits function for all Americans.

Changes in Adult Coverage

The ACA's expanded coverage is primarily targeted at adults. The ACA allows for the expansion of Medicaid eligibility to all nonelderly adults under 138 percent of FPL.⁵⁰ The coverage expansion occurs in conjunction with a dramatic simplification in how family income is measured, including eliminating "asset tests," which have historically barred adults from coverage if they had savings of more than a few thousand dollars.

The law also establishes health insurance exchanges (now often called "marketplaces"), where families and individuals can purchase private health insurance coverage without regard to health status. Federal refundable tax credits are provided to those with incomes between 100 and 400 percent of FPL who do not have another source of coverage.

The ACA's provisions related to Medicaid, CHIP, and subsidies or tax credits are projected to cover approximately one in five Americans by 2019 and reduce the nation's overall uninsurance rate to 11 percent.^{51, 52} If fully implemented, the ACA's Medicaid expansion would provide new coverage to 4.6 million reproductive-age women, 2.7 million parents, 2.9 million Hispanic adults, and 2.8 million Black adults.⁵³

One of the first ACA provisions to go into effect was the requirement that health insurance plans allow young adults up to age 26 to remain as dependents on their parents' policies. Experts estimate this provision alone is directly responsible for providing health insurance coverage for approximately 3 million young adults.⁵⁴

Changes in Children's Coverage

Although focused on adults, the ACA also has significant impact on children's coverage. Just as it does for adults, the ACA expands Medicaid eligibility to all children in families with incomes below 138 percent of FPL. The practical effect of this option is to move millions of children in 21 states from CHIP coverage to Medicaid coverage.⁵⁵ Medicaid coverage brings with it a more comprehensive benefit package and tighter limits on out-of-pocket health costs for families. In some states, however, it may also place limits on which doctors may be seen.

The ACA also prevents states from scaling back existing children's coverage in CHIP or Medicaid through September 30, 2019. States have been able to place enrollment caps on the CHIP program since the program's creation. If a child is ineligible for CHIP on the basis of an enrollment cap after January 1, 2014, the child becomes eligible for tax credits to subsidize the purchase of a plan through the health insurance exchange. Although the ACA maintains the CHIP program through 2015, and provides enhanced federal funding to states if CHIP is reauthorized beyond that date, the

The Commonwealth Fund reported that nearly 57 million low-income families were underinsured in 2012 – meaning they were at high risk of economic ruin in the face of a single health episode.

program itself is not reauthorized and its future remains uncertain.

Changes in Insurance Coverage and Benefits

The Act prohibits insurers from refusing to cover individuals with pre-existing health conditions, mandating that insurers offer coverage to all children and adults regardless of their health status. This change went into effect for children at the first plan renewal following the Act's passage and began for adults on January 1, 2014. Insurers must also eliminate annual and lifetime benefit caps. These limits on what insurers pay put individuals at risk of accumulating medical debt and losing access to care — a particular concern for families with sick children.

The Kaiser Family Foundation estimates that, because 24 states have declined the Medicaid expansion, 5 million people fall into a “coverage gap” – they are too poor to obtain assistance on the health insurance exchange, but they do not meet their state's restrictive Medicaid eligibility requirements.

The ACA also requires the development of Essential Health Benefits (EHBs) that must be included in most private insurance plans and the expanded Medicaid program. The EHBs must include 10 major benefit categories,

including ambulatory, emergency, maternity and newborn care, mental health and substance abuse services, preventive and rehabilitative services, and chronic disease management.⁵⁶ The EHBs also include pediatric vision and dental care. Insurance plans must provide preventive services without cost sharing, including preventive care for infants, children, adolescents, and women. For infants and children, the services recommended by the American Academy of Pediatrics' Bright Futures initiative must be included, which means developmental and behavioral assessments and a range of physical health screenings are covered.⁵⁷

limitations for mental health and substance use disorder services above those required for medical benefits.⁵⁸ A projected 32.1 million individuals will gain mental health, substance use disorder services, or both benefits under the ACA.⁵⁹

The ACA's insurance changes are of particular relevance for mental health. In addition to expanding coverage to many who may need mental health and substance use disorder services, the new essential health benefits package includes parity in coverage between mental and physical health. Adult depression screenings are included in the preventive services that must be offered at no cost. The ACA, in combination with the Mental Health Parity and Addiction Equity Act of 2008, ensures that plans do not require cost sharing or treatment

Essential health benefits that must be included in most private health insurance plans and the expanded Medicaid program under the ACA

Ambulatory care	Chronic disease management
Emergency care	Pediatric vision and dental care
Maternity and newborn care	Developmental behavioral assessments for children
Mental health and substance abuse services	Physical health screenings for children
Preventive and rehabilitative services	

UNFINISHED BUSINESS

The ACA set into motion a large number of changes that expand health insurance and improve that coverage for vulnerable families. However, a great deal of additional work is necessary to secure the ACA's gains for children and their families. The unfinished business falls into three categories: 1) extending eligibility to all vulnerable families, 2) assuring continuous enrollment in health insurance programs, and 3) minimizing the financial burdens on these families.

1. Extending Eligibility

As indicated earlier, health insurance is a critical element of whole family well-being and, thus, eligibility for Medicaid is especially important for low-income families. While the ACA was designed to provide affordable coverage options to all low- and moderate-income families legally in the United States, the Supreme Court's ruling in *NFIB v. Sebelius* allows states to reject the law's adult Medicaid expansion provisions (and thus forego the federal funding attached to them), in effect, permitting them to deny Medicaid coverage to millions of individuals who the law was designed to make eligible. For those pursuing the two-generation approach, increasing the number of states that adopt the Medicaid expansion, with its critical role in promoting the health and well-being of vulnerable parents and children, should be a central focus.

As of August 2014, 24 states have declined to expand their Medicaid program.⁶⁰ As a result, the Kaiser Family Foundation estimates that 5 million people fall into a "coverage gap" — they are too poor to qualify for premium assistance on the health insurance exchange, but they do not meet their state's restrictive Medicaid eligibility requirements.⁶¹ This group includes over half of the 4.9 million parents who were slated to gain coverage through the ACA but had no subsidized coverage option in 2014 as a result of state decisions to decline the Medicaid expansion.⁶² The states that have declined the coverage expansion have a disproportionately large share of Black and Hispanic individuals among their uninsured population.⁶³

Despite this disappointing result, there are many opportunities for health care improvement in states that have rejected the opportunity to expand their Medicaid programs. The ACA still includes important mandatory changes in Medicaid. States are required to simplify eligibility

standards, eliminate asset tests, and expand eligibility for all children up to 138 percent of FPL, regardless of their decision regarding expanding Medicaid coverage for adults. States must move forward with the Medicaid changes even if they elect not to expand the program.

2. Assuring Continuous Enrollment

The ACA's first open enrollment period ended on March 31, 2014. Data from this period has been released, and continued analysis will yield valuable lessons for future enrollment seasons. A recent report estimates net gains in coverage of 9.3 million people.⁶⁴ While these figures suggest significant progress in reducing the number of vulnerable parents and children without health insurance, a great deal of work remains if the ACA is to reach its potential in supporting vulnerable families. Achieving enrollment goals requires streamlining the enrollment process, finding and enrolling those who are uninsured, and ensuring that those who enroll do not return to the ranks of the uninsured.

3. Streamlining Enrollment

The ACA envisions a "no wrong door" approach to eligibility and enrollment, allowing individuals to submit a single application online, in person, by mail, or by phone. They are then routed into the correct avenue for coverage: Medicaid, CHIP, or premium subsidies.

Since 2009, states have had the option of adopting Express Lane Eligibility, which allows states to borrow eligibility findings from other human services programs to enroll eligible children in health coverage. Federal guidance issued in 2013 gave states permission to adopt similar strategies when enrolling adults.⁶⁵

States can now use TANF, SNAP, WIC, and free and reduced lunch program income eligibility findings as a proxy for Medicaid income determinations for children and adults.^{**} As of March 2014, more than half a million individuals in five states (Arkansas, California, Illinois, Oregon, and West Virginia) had been determined eligible for Medicaid and CHIP based upon their SNAP eligibility.⁶⁶ Three states (New Jersey, Oregon, and West Virginia) are utilizing a new federal option to identify and enroll eligible parents in Medicaid using their children's eligibility information.⁶⁷ These opportunities are available to other states, but they have not yet chosen to use them.

Outreach

State and local governments, health care providers, and community organizations have a great deal of experience identifying and helping people obtain health insurance. Yet, the evidence base for specific strategies is limited, and the evidence we do have may not apply equally well to some of the hard-to-reach populations gaining coverage under the ACA. Given the racial and ethnic composition of the currently uninsured population, outreach and enrollment efforts will need to particularly target minority populations and those with limited English language proficiency.

The Act creates two forms of assistance for new enrollees. Navigators are guides who help families consider their options on the health insurance exchange and enroll in the coverage that best meets their needs. Consumer Assistance Programs assist families with all types of coverage, including Medicaid.⁶⁸ Funding for these programs is limited, and creating burdensome certification standards for navigators is one technique states have used to express their opposition to the ACA. Supporting the work of navigators and Consumer Assistance Programs is essential to ensuring that

vulnerable families are able to obtain the coverage that best meets their needs.

Maintaining Coverage

Unlike employer-based coverage, which usually occurs at the time of employment and then remains stable as long as the person is employed, public insurance programs require annual (and sometimes more frequent) reenrollment. Prior experience shows that enrollment gains for children and adults can be reversed if those who enroll fail to renew when their coverage expires.⁶⁹

States can increase the stability of coverage by adopting policies such as 12-month continuous eligibility, which eliminates the need for mid-year eligibility determinations. States can also become proactive about renewals — pre-completing applications or defaulting to a renewal unless the enrollee indicates a change in circumstances — rather than passively waiting for people to complete a renewal process. For example, Illinois is currently experimenting with sending shortened and pre-populated renewal forms to current program enrollees.⁷⁰

Avoiding Coverage Gaps

The complex coverage scheme of the ACA means that different members of a single family or household may be covered by different health insurance programs. Income volatility among low-income families will cause many families to lose one source of coverage and, while they will likely become eligible for a different

⁶⁸ Temporary Assistance for Needy Families (TANF) is a federal assistance program that provides cash assistance to qualified low-income families with children. The Supplemental Nutrition Assistance Program (SNAP) is a federal program that provides food-purchasing assistance for qualified low-income families. The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a federal program that supports the health care and nutrition of low-income pregnant or breastfeeding women and infants and young children. The National School Lunch Program gives cash reimbursements for food services to children in participating schools. Children may qualify for either free or reduced-priced lunches (and other meals through additional programs) based on their family's income.

source, the transition to that new coverage will not be automatic. Researchers estimate that half of adults with incomes below 200 percent of FPL will experience at least one change in insurance coverage within a year.⁷¹ Forty-three percent of these adults are parents, whose children may also experience coverage changes. While this is better than pre-ACA days, where many of those shifts would have been between having coverage and being uninsured, navigating this complex system creates its own challenges.

One challenge is to assure that families move from one form of coverage to another, and that they do not accidentally become uninsured even though they are eligible for insurance. Another challenge is to assure families have continuity in their health plan or provider even as the source of payment for that plan or provider changes. Tennessee and Washington have explored the development of “bridge” programs to unite family members on the same plan, regardless of subsidization source.^{72,73}

Maternity-Related Coverage

The perinatal period is one where coverage disruptions are likely — and likely to have significant adverse effects on vulnerable families. For example, Medicaid coverage for a pregnant woman ends two months after the birth of her child.⁷⁴ Historically, this often resulted in the mother losing her insurance. Under the ACA, she is likely to either retain her Medicaid eligibility or become eligible for coverage in the exchange, but this transition to a new eligibility category is not automatic.

Attention to helping new mothers make this transition is warranted.

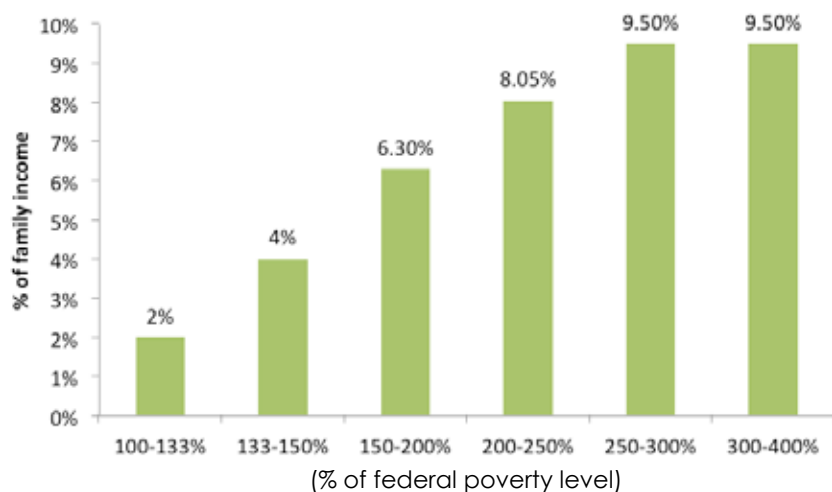
The ACA eases the post-pregnancy transition through the availability of subsidized qualified health plans on the exchange and, in states that choose to expand, broader Medicaid coverage for parents. Today, 30 states have federal approval to provide a limited set of pre- and post-conception family planning services to those who are not eligible for full Medicaid benefits.⁷⁵ This coverage includes access to contraception, necessary examinations, and laboratory testing, including sexually transmitted infection treatment, in some states. Slightly more than half of these states provide services to men and women.

Researchers estimate that half of adults with incomes below 200 percent of FPL will experience at least one change in insurance coverage within a year.

As important as these services are, they are not the same as comprehensive health insurance that promotes overall parental health. In some states, limited family planning coverage will be replaced by comprehensive health insurance under the ACA. For families to realize this theoretical benefit, states and supporting organizations will need to help parents, especially new mothers, navigate their changing health insurance options.

Coverage for pregnant women is also easily disrupted. Generally states provide Medicaid coverage to pregnant women with incomes up to 200 percent of poverty.⁷⁶ Women covered through the health insurance exchange with

Maximum Exchange Premium Costs as Share of Income, Family of Four in 2014



Source: Analysis by National Academy for State Health Policy, 2014.

incomes between 133 percent of FPL and their state's pregnant woman Medicaid eligibility threshold can be concurrently enrolled in Medicaid and the exchange. However, state eligibility systems must be modified to accommodate this change.

Medicaid coverage offers certain advantages, including enhanced prenatal services, since the program is oriented toward pregnant women. However, benefits for pregnancy-related services vary widely across states. In addition, interruptions in coverage for those transitioning between Medicaid and the Exchange can disrupt care at a critical time. In particular, women may have to enroll in a new Medicaid managed care plan and find an obstetrician who participates in that plan. States will need to focus on rapid and smooth coverage transitions at this point to assure access to appropriate maternal and prenatal care that is essential to healthy birth outcomes.

Coverage for Justice-Involved Families

Adults leaving incarceration are another group to target for Medicaid enrollment. Most prisoners, men or women, are parents.⁷⁷ The ACA's Medicaid expansion provides insurance coverage for adults leaving incarceration, but, as with other eligibility categories, enrollment is not automatic. Immediate enrollment of these adults into Medicaid upon release can provide them with necessary physical and mental health services that will support their parenting.

Children's Coverage

Despite significant progress in covering children over the past two decades, much work remains. Medicaid and CHIP have been tremendously successful in cutting the uninsured rate for children from 14 percent to 7 percent.⁷⁸ The ACA has focused the nation's attention on coverage for adults, but continued efforts are needed to reach those last 7 million children.

MINIMIZING FINANCIAL BURDENS

While the coverage expansions in the ACA should help millions gain access to needed health care services, most coverage options are not free, and families will incur additional costs every time they go to the doctor or hospital. High costs can be a barrier to access, undermining the value of health insurance. High costs can impede families' ability to make other investments — in their education or in stable housing — that are critical to family success. The overall cost of health care is such that all but the poorest families can expect to

contribute to the cost; minimizing the financial burden is an important aspect of supporting vulnerable families. This can be achieved by assuring that subsidies are sufficient to cover the cost of health insurance premiums and protecting against gaps in coverage.

Coverage Subsidies

Insurance coverage purchased through health insurance exchanges is subsidized for most individuals, but the subsidy structure still leaves families at risk for significant health care costs. As shown in the figure on page 24, families are limited in the percentage of their income they must pay for health insurance, but even 5 or 6 percent of income will be difficult to afford for many families, particularly those with extraordinary costs (e.g., costs associated with a child with special health care needs).

In addition to the premium payments, families incur costs associated with the health care services they use. Products offered on the exchange vary a great deal, but many have deductibles of thousands of dollars that must be paid by the family before the insurance benefits kick in. For some families, the ACA provides subsidies toward these deductibles.

A few quirks in the law may also increase the financial burden for families. Families with an offer of coverage through their job can only obtain premium subsidies if the employer plan is unaffordable, but the affordability standard applies only to the coverage of the employee, not to his or her family. And premiums the family pays for the CHIP program (which charges a

High costs of coverage can impede families' ability to make other investments – in their education or in stable housing – that are critical to family success...minimizing the financial burden is an important aspect of supporting vulnerable families.

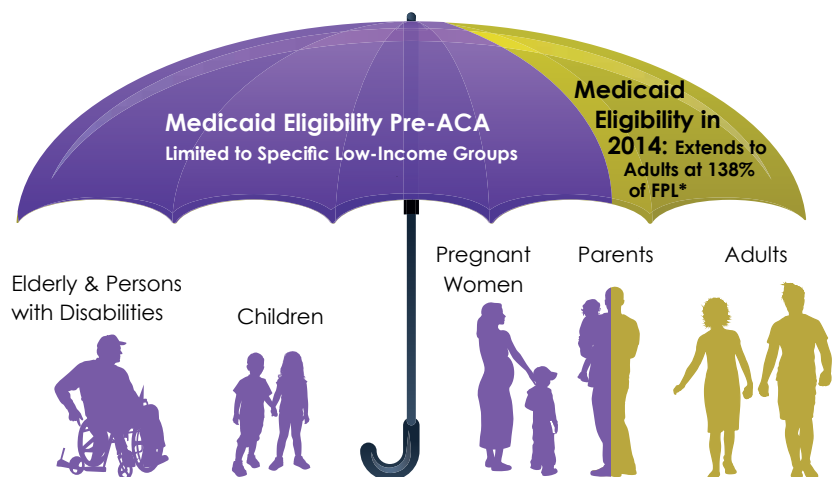
premium in 33 states) are not counted in the affordability formulas.⁷⁹

Coverage Gaps

Based on current state decisions, 5 million adults fall into the coverage gap with incomes too low to obtain assistance on the health insurance exchanges but too high to qualify for Medicaid.⁸⁰ Undocumented immigrants are ineligible for any of the ACA's coverage options and are barred from purchasing coverage in the health insurance exchanges with their own money. And, despite the mandate in the ACA that everyone purchase coverage if an affordable option is available, many millions are expected to go without coverage.

Black adults are disproportionately represented in the coverage

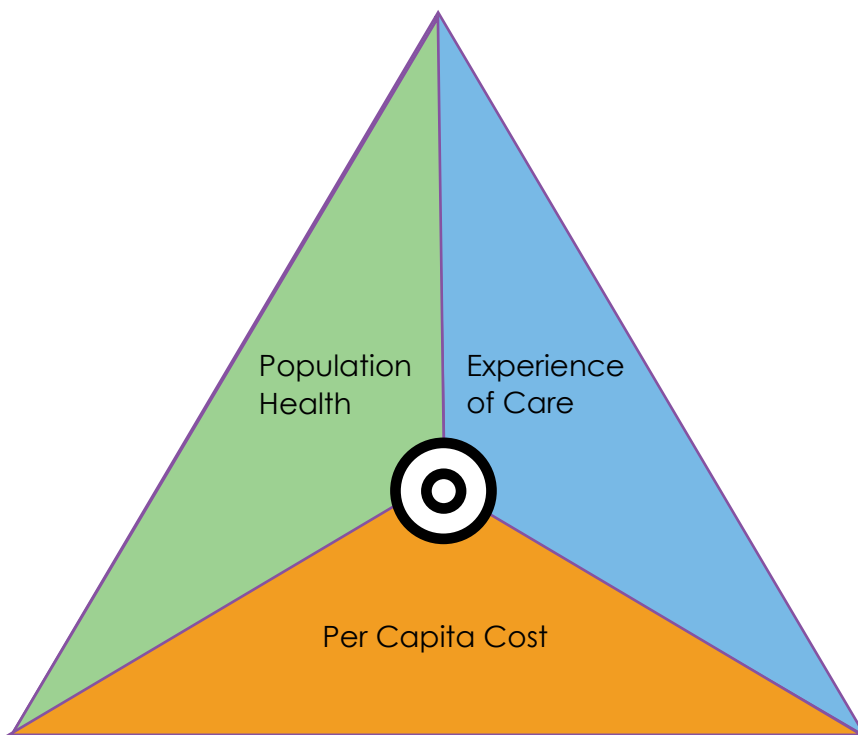
The ACA Medicaid Expansion Fills Gaps in Coverage



Note: The June 2012 Supreme Court decision in *National Federation of Independent Businesses vs. Sebelius* maintained the Medicaid expansion, but limited the Secretary's ability to enforce it, effectively making the expansion optional for states. *138% FPL=\$15,856 for an individual and \$36,951 for a family of three in 2013. Adapted and reprinted with permission from the Kaiser Family Foundation.



Triple Aim



gap, as states with large Black populations — including Florida, Georgia, and Texas — have rejected the Medicaid expansion.⁸¹ Fifty-three percent of those in the coverage gap are people of color.⁸² Hispanics already have the highest rates of uninsurance in the country, and they are disproportionately represented among those barred from enrollment due to immigration status. Nearly one in three nonelderly American Indians is uninsured, and over 60 percent of that group have incomes that make them eligible for the Medicaid expansion in states that choose to expand.⁸³

While the essential health benefits offered in commercial health

insurance are comprehensive, there are important gaps for children. In particular, services such as occupational and physical therapy to address developmental delays are not included. Without such coverage, families will either need to pay for these services out of their own resources or go without needed services.

The ACA reduced funding to hospitals that serve the uninsured on the basis of the expectation that those uncompensated care burdens would decline. At the same time, the ACA established the Community Health Center Fund, which provides \$11 billion over five years to support ongoing health center operations, the creation of new health centers in medically underserved areas, and the expansion of services in existing health centers.⁸⁴ Health centers serve a disproportionate share of racial and ethnic minorities and people without health insurance. To the millions of vulnerable families that remain without health insurance, a robust safety net of service providers is an essential component of a health care system that provides two-generation support.

Fifty-three percent of those in the coverage gap are people of color.

PART II:

ORGANIZING THE HEALTH CARE SYSTEM TO PROMOTE FAMILY WELL-BEING

While health insurance coverage is an important cornerstone of family economic success, new approaches to the organization of the health care system can also significantly impact family well-being. In fact, the organization of the health care system offers some of the most intriguing opportunities for two-generation efforts. This section describes how the health care system is evolving, how the ACA is catalyzing that evolution, and the work that remains to create a health system organized to promote family well-being.

Despite having the most costly health care system in the world, Americans' lives are shorter and less healthy than those of people in many other industrialized countries.⁸⁵ Our relatively poor health reaches across income categories, although the burden of our underperforming health system falls disproportionately on those who are most vulnerable.

When the Institute of Medicine defined health care quality in 2001, one of the six elements was equity.⁸⁶ In 2003, the Agency for Healthcare Research and Quality (AHRQ) issued its first report on health disparities.⁸⁷ A decade later, racial and ethnic minorities and low-income families still face barriers accessing high-quality care. AHRQ's 2013 health disparities report showed that Black, Hispanic, American Indian, and Alaska

Native populations received lower-quality care than non-Hispanic White populations along many dimensions.⁸⁸ Poor, low income, and middle-income families were also more likely than high-income families to receive poor quality care.

While many measures are improving, AHRQ reported worsening quality across a range of areas, including childhood flu vaccinations, maternal mortality rates, cervical cancer screenings, and diabetes complications — all areas where declining quality places parents and their children at risk. Some racial disparities in these areas are improving, while others — including maternal mortality for Black women compared to White women — have stayed the same or gotten worse.

There is a growing understanding that shortcomings in the organization and delivery of health care play a role in this country's poor health outcomes. The American health care system is often described as a cottage industry and not a "system" at all. Most health care services (doctors' visits, hospital stays, medications, etc.) are delivered to individual patients on a piecemeal basis. Despite the fact that it makes up one-sixth of the U.S. economy,

The Institute of Medicine has identified six elements of quality for the delivery of care in the United States.

- 1. Safe** - Avoiding preventable injuries, reducing medical errors
- 2. Effective** - Providing services based on scientific knowledge (clinical guidelines)
- 3. Patient centered** - Care that is respectful and responsive to individuals
- 4. Efficient** - Avoiding wasting time and other resources
- 5. Timely** - Reducing wait times, improving the practice flow
- 6. Equitable** - Consistent care regardless of patient characteristics and demographics

The health care system makes up one-sixth of the U.S. economy.

the entire health care sector is badly underinvested in information technology, quality measurement, and formal quality improvement methods.

The U.S. health care system is heavily oriented toward specialty care (as opposed to general practice or primary care) and focuses on responding to acute medical episodes (as opposed to managing chronic conditions). This orientation is embodied in public and private health care coverage, which pays specialist physicians and those who perform procedures much more than it reimburses primary care providers for their services, such as well-child visits or care coordination.

Despite having the most costly health care system in the world, Americans' lives are shorter and less healthy than those of people in many other industrialized countries.

In part due to its scale, and in part due to its design, health care forms its own ecosystem separate from the other aspects of life that contribute to health and well-being. Doctors and hospitals have historically had few reasons to interact with the social systems that might serve their patients. Private health insurance focuses exclusively on health care services. Medicaid is an exception — providing long-term services and supports to those who need them (and are eligible for them) and developmental supports

for children. But these additional services are often added on and are not a vehicle for integration between social and medical needs.

High health care costs are not only a barrier to obtaining care, but they also place an extra burden on lower-income families through higher taxes, foregone wages, and by making fewer resources available for other critical human capital and physical investments. By one estimate, almost the entire increase in the median family's earnings between 1999 and 2009 was consumed by direct or indirect (taxes and foregone wages) costs associated with health care.⁸⁹

THE EVOLVING HEALTH CARE SYSTEM BEFORE THE ACA

Clinical and policy leaders have been aware of the shortcomings of the U.S. health care system for decades, but consensus regarding the need for change has only formed recently. Substantial disagreement remains regarding the best path forward and the mechanisms that should be used to effect change. Still, some trends are taking hold — innovative ways of paying health care providers, a new framing for the health care system known as the Triple Aim, and increasing attention to social factors that affect health and well-being.

Payment methods within health care are now seen as a major problem in the health care system. Traditionally health care providers are reimbursed for their services on a fee-for-service basis. That is, hospitals, doctors, and other clinicians submit a bill for each service delivered, and they are paid one service at a time. There

has been a growing understanding in recent years that fee-for-service payment methods not only drive up health care costs, but they also encourage fragmented care that fails to meet the medical needs of patients — particularly those with complex needs and chronic conditions.

With fee-for-service payment, each provider is accountable for the care he or she delivers, but no one is accountable for overall patient outcomes. Many alternative payment methods are being explored (some are described below). These alternative methods embrace shared accountability for outcomes among groups of providers and more flexibility for those providers to allocate resources as they see fit to improve patient outcomes.

In 2008, a group of health system experts developed the concept of the “Triple Aim” as a framework for U.S. health care system improvement.⁹⁰ The goals of the Triple Aim are threefold: improved patient experience of care, improved population health, and reduced per capita health care costs. The Triple Aim is radical in two important ways. First, it explicitly embraces cost as an attribute of the health system, replacing the outmoded view that “cost containment” is something imposed from the outside on the health care system. Second, by including the goal of population health improvement, the Triple Aim suggests clinician accountability beyond the individual patient interaction.

The Triple Aim has been embraced at the highest levels of government.^{***} Despite broad

consensus on the need to reorient the health care system toward the Triple Aim, progress has been slow. Resources within health care remain overwhelmingly concentrated in systems that respond to acute health care needs, with a very gradual reallocation toward slowing the onset and progression of chronic conditions.

With fee-for-service payment, each provider is accountable for the care he or she delivers, but no one is accountable for overall patient outcomes.

The last decade has seen increased attention to the social determinants of health — social factors such as safe housing, good nutrition, economic resources and the like — that have a direct effect on people's health and well-being. And poor health can contribute to economic instability that further affects well-being. For example, families in poverty may live in neighborhoods that lack healthy food options. High crime rates, more common in neighborhoods with higher rates of poverty, may generate safety concerns about walking and outdoor exercise. Both these factors can contribute to chronic health conditions that make it difficult to acquire or maintain employment or attend classes. Ascend's two-generation framework recognizes the interconnectedness of health and well-being to other components, like education: All play a role in a family's economic success and ability to thrive.

^{***}One of the Triple Aim's creators was Dr. Don Berwick, who later became the administrator of the federal Centers for Medicare and Medicaid Services.

Recognition of these interactions is not new to the health field. When Dr. H. Jack Geiger opened America's first community health center in 1965, he wrote malnourished patients prescriptions for food, which they could redeem at the health center's fully stocked pharmacy.⁹¹ Today, nearly 50 years later, myriad efforts are being made to bridge the worlds of health care and public health and consider health needs in the context of social needs. However, these efforts remain isolated, fairly small scale, and generally poorly funded. Nonetheless, as the health care system increasingly considers and treats patients in their milieu, it has the potential to play a much stronger role in promoting intergenerational opportunity.

The last decade has seen increased attention to the social determinants of health – social factors such as safe housing, good nutrition, economic resources and the like – that have a direct effect on people's health and well-being.

CHANGES UNDER THE ACA

The Affordable Care Act dramatically accelerates fundamental shifts in how health care services are delivered and financed. The Act contains a range of initiatives designed to pilot, evaluate, and scale innovative approaches to payment and delivery that move the health care system from fee-for-service reimbursement toward financing models that reward value-based, whole-person care. To spearhead these efforts, the ACA created the Center for Medicare and Medicaid Innovation, with funding of \$10

billion over 10 years, to experiment with and spread strategies that move the health care system toward the Triple Aim. Many of these efforts target Medicare, the federal program that covers everyone over age 65, while others focus on adults and children.

REORGANIZING CARE IN MEDICARE

The ACA includes numerous changes to the Medicare program designed to promote care coordination and deliver high-value care. Because Medicare primarily serves the over-65 population, Medicare policy may seem irrelevant to the needs of families and children. Medicare's connection to the two-generation approach is through its dominant role as a payer — providing, for example, nearly 40 percent of a typical hospital's revenue.⁹² Medicare can serve as a catalyst (or an impediment) to health system improvement due to its sheer size. Medicare is also important to vulnerable families in its own right, since grandparents play a growing role as primary caregivers or guardians of children in lower-income families.

A thorough review of the changes Medicare is leading is beyond the scope of this paper. A few of the most important and relevant initiatives include:

- **The Bundled Payments for Care Improvement Initiative.** This is a national Medicare pilot program providing pre-set payments for care over an entire procedure or diagnosis event. For example, a knee replacement surgery bundle provides a lump sum reimbursement for the facility, surgical care, replacement

knee, and pre- and post-operative care. Bundled payments are designed to encourage efficient resource utilization and coordinated care that minimizes the need for returns to the hospital or extensive rehabilitation.

- **The ACA expansion of various payment penalties designed to discourage poor care.** Since 2008, Medicare has declined to pay to fix so-called “never events,” such as performing surgery at the wrong site or leaving foreign objects inside the body. The ACA greatly expands this model by reducing payment rates to hospitals that have excessive rates of readmissions — people returning to the hospital shortly after discharge — and to hospitals with various avoidable infections.
- **Accountable Care Organizations as a new provider type within the Medicare program.** Accountable care organizations are groups of providers that have the opportunity to share in any savings — and sometimes share in losses — achieved while providing care for a group of patients, as long as health care quality is maintained or improved.

Each of these Medicare initiatives has corollaries in the private insurance market and in many state Medicaid programs.

REORGANIZING CARE FOR ADULTS AND CHILDREN

The ACA also contains provisions designed to improve care delivery for adults and children.

The ACA also contains provisions designed to improve care delivery for adults and children. As of June 2014, three of the most important provisions reach primary care practices in 18 states.

The law accelerates a move to create models of care, such as the patient-centered medical home (PCMH), that support primary care clinicians in delivering comprehensive care. The PCMH is an enhanced model of primary care in which a team of health care professionals, led by a primary care clinician, works together to provide coordinated, comprehensive, patient-centered care.⁹³ One ACA initiative supports primary care clinicians through aligned funding across Medicare, Medicaid, and private payers.⁹⁴ Another initiative helps primary care practices build a stronger practice infrastructure to serve high-need patients.⁹⁵ Yet another provision of the ACA establishes a health home opportunity through which state Medicaid programs can receive resources to support comprehensive services for people with multiple chronic conditions.⁹⁶ Together, as of June 2014, these three initiatives reach primary care practices in 18 states.

The ACA supports 10 states that are experimenting with providing incentives in their Medicaid programs to prevent and better manage chronic disease through participation in evidence-based prevention programs and the adoption of healthy behaviors.⁹⁷ Programs address smoking cessation, weight loss, lowering cholesterol and blood pressure, and prevention or better management of diabetes. Although most states are focusing on adult populations,

Nevada is including children, and Wisconsin and Connecticut are engaging pregnant women to improve birth outcomes.⁹⁸

UNFINISHED BUSINESS

Additional work is necessary to secure the ACA's gains for children and their families. The unfinished business falls into three categories: advancing integration within the health care system, coordinating human services and medical services, and promoting equity through accountability of care.

ADVANCING INTEGRATION WITHIN THE HEALTH CARE SYSTEM

Ensuring that health care is integrated across all care settings and providers is essential for improving outcomes for vulnerable families. Different physician specialists rarely communicate with each other about the patients they have in common. Acute episodes at a hospital are often handled by a separate medical team than the one the patient sees for outpatient care. Physical, mental, and oral health providers operate in entirely separate systems with completely separate payment methods. Public health departments and public health initiatives seek to meet the health needs of a population but generally operate completely independently from the personal health care systems that deliver care to individual patients. There are several ways in which the health care system can improve integration across providers and

settings, including coordination through medical homes, creating accountable care organizations, and redesigning the health care workforce.

Building From the Patient-Centered Medical Home

The starting point for integration is the PCMH, which supports a stronger primary care foundation for patient care. The PCMH model has been shown to reduce racial and ethnic disparities in care and increase patient satisfaction with access to care.^{99, 100}

With almost every state taking major steps to develop medical homes, the next phase in care improvement is coordinating the care among providers and facilitating their work in teams. Various efforts are underway around the country to bring these systems together to better meet the comprehensive health needs of patients.

In the 1990s and early 2000s, many Medicaid agencies “carved out” mental health services from physical health services, believing they could obtain better management of those services from plans that specialized in that area. This legacy remains but serves as an impediment to the clinical integration now generally recognized as necessary. The general trend is now toward “carving in” these services, but this transition is incomplete. Many states are seeking to integrate behavioral health and substance abuse services with primary care, with clinics in many states providing behavioral health and substance use disorder services with primary care visits and providing same-

As of April 2014, 19 states were pursuing some type of accountable care model in their Medicaid or CHIP programs.

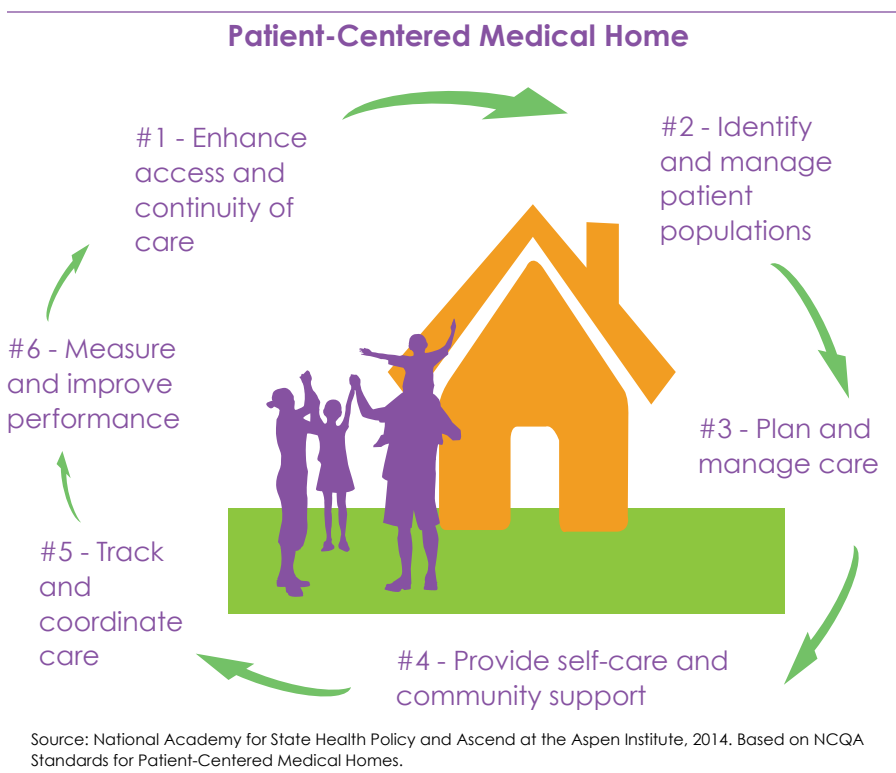
day follow-up with psychologists, licensed social workers, and other providers as needed to address behavioral health needs.

Some states are targeting specific populations to build a more coordinated care model. Under special funding provisions of the ACA, Rhode Island's health homes provide care coordination for children with special health care needs and their families, helping families "reach their full potential" and access needed services.¹⁰¹ The state also provides health home services to adults with mental illnesses or substance abuse disorders. Rhode Island and Iowa link behavioral and physical health care by providing services to adults with serious mental illnesses. Iowa also provides health home services to children with serious emotional disturbances.^{102, 103}

Building Accountable Care Organizations

As of April 2014, 19 states are pursuing some type of accountable care model in their Medicaid or CHIP programs, in many instances building off the Medicare ACO model.¹⁰⁴ The idea is to encourage teams of care spanning the continuum from primary care through specialized hospital care to accept a fixed payment for a group of people and accept accountability for assuring that they receive necessary, high-quality care.

A leading state-level example is Oregon's Coordinated Care Organizations (CCOs), which are local health entities that operate under a single budget to provide coordinated and integrated physical, mental, behavioral,



and (soon) oral health care for Medicaid enrollees. CCOs are accountable for the quality and cost of care; they track and report on the quality of care they provide to children and adults and are expected to help the state contain health care costs. Early results are promising: beneficiaries served by CCOs have seen more than a 30 percent decrease in hospitalizations for both heart failure and chronic obstructive pulmonary disease over the first nine months of 2013.¹⁰⁵ CCOs also demonstrate a 32 percent increase in screening of young children for developmental, behavioral, and social delays. Decreases in emergency department utilization and spending are mirrored by increases in primary care visits and spending.

New models of care delivery with a primary care emphasis and a team-based approach require revisiting the nature of the health care workforce, which was largely trained for a different type of medical practice.

Trendspotting: leading state models

Rhode Island's health homes provide care coordination for children with special health care needs and their families, helping families "reach their full potential" and access needed services. They also provide health home services to adults with mental illnesses or substance abuse disorders.

Rhode Island and **Iowa** link behavioral and physical health care by providing services to adults with serious mental illnesses. Iowa also provides health home services to children with serious emotional disturbances.

Oregon's Coordinated Care Organizations (CCOs) are local health entities that operate under a single budget to provide coordinated and integrated physical, mental, behavioral, and (soon) oral health care for Medicaid enrollees. Oregon also has linked health care transformation to school readiness.

A number of states, including **Vermont**, are creating interdisciplinary Community Health Teams staffed with social workers, public health specialists, nutritionists, and other professionals to provide intensive care coordination, link to human services, and offer in-home support to families through Medicaid-supported programs.

The state is facilitating the spread of the CCO model to public employee benefits, beneficiaries dually eligible for Medicare and Medicaid, and commercial payers.

Oregon also has linked health care transformation to school readiness. In recognition of the interconnectedness between health and education, the state is modeling its early learning system transformation after CCOs by emphasizing care coordination and outcomes-based results. It is in the process of aligning the two reforms to create accountability among health care and early learning providers for child outcomes.¹⁰⁶

Coordinated care organizations also demonstrate a 32 percent increase in screening of young children for developmental, behavioral, and social delays.

Developing the Appropriate Workforce

New models of care delivery with a primary care emphasis and a team-based approach require revisiting the nature of the health care workforce, which traditionally has been trained for a different type of medical practice. Changes are needed at all levels, including physician education that emphasizes team care and updating the scope of nurses' licenses to reflect the care they can safely and competently deliver given their training. Credentials must be defined for those playing supportive roles, such as community health workers, who help people manage their own care needs more effectively.

In late 2013, the federal government announced plans to assist health centers in making facility modifications to better deliver care as a PCMH, integrating behavioral health services and strengthening team-based care for the vulnerable children and parents they serve.¹⁰⁷ New Medicaid policies also allow states to pay for preventive services delivered by a broad range of health professionals so long as the services are recommended by a licensed professional.¹⁰⁸

Distribution of the workforce is an ongoing concern, with acute shortages of health care professionals in many rural, frontier, and inner-city urban areas. The increased use of telemedicine, combined with federal and state regulation that supports its use, may improve care coordination and ameliorate some access issues in rural areas. The ACA supports a variety of workforce initiatives,¹⁰⁹

but much additional work will be required to prepare and support the workforce to meet the needs of a newly insured, aging, and increasingly ethnically diverse population.

COORDINATION OF HUMAN AND MEDICAL SERVICES

A whole-person or whole-family orientation to care meets social needs as well as medical needs. Accountable care models that place health systems at financial risk for health outcomes are designed in part to encourage those systems to address social needs and the social determinants of health. For example, if a hospital is penalized financially for having too many of its patients return quickly to the hospital, it has an incentive to assure that children hospitalized for asthma have a care plan and necessary home supports that make returning to the hospital unlikely. Various initiatives are underway to create formal linkages between the health care system and the human services system using community health teams, “hotspotting,” and integrated eligibility systems.

Community Health Teams

A number of states, including Vermont, are creating interdisciplinary Community Health Teams staffed with social workers, public health specialists, nutritionists, and other professionals to provide intensive care coordination, link to human services, and offer in-home support to families through Medicaid-supported programs. Medicaid’s Maternal, Infant and Early Childhood Home Visiting Program, greatly expanded by the ACA, provides medical care, behavioral care,

health education, and human services assistance for at-risk mothers and their children. With support from the Commonwealth Fund, the National Academy for State Health Policy’s Assuring Better Child Health and Development project has supported dozens of states in improving their identification of children at risk of developmental delays and linking those children to early intervention services that can place them on a better life trajectory.

Hotspotting

A growing trend in health care is so-called “hotspotting,” a methodology designed to identify the highest-cost and highest-need patients and provide intensive resources to address those concerns. The leaders in this field have come to realize that the largest barriers to health are often unstable living conditions and unmet basic economic needs. New York, for example, is experimenting with providing supportive housing for high-risk homeless Medicaid patients, the costs of which are likely to be offset by health care savings.¹¹⁰ Inherent in the hotspotting approach is viewing the patient and his or her needs in the context of his or her neighborhood and family.

The largest barriers to health are often unstable living conditions and unmet basic economic needs.

These examples are intriguing and encouraging, but they represent a small slice of how health care is practiced in America. Continued work to bring health and social systems together is necessary to

meet the needs of vulnerable families. Yet, there are also risks to doing so under the “health” umbrella. The general frame of the health care system is one of diagnosis, treatment, and cure. This stands in contrast to human service systems that often take a more holistic view of family assets and a life course perspective. Greater integration of health and social supports is needed, but, currently, no single model has been determined to be optimal for children and parents.

Integrating Eligibility

For many vulnerable families, obtaining health and social supports requires eligibility determinations from a number of disparate programs from various state and local agencies. The ACA provides states with significant federal funding to rebuild their health care eligibility systems. Some states have taken advantage of this opportunity to redesign those systems to include social supports as well. For example, Wisconsin has a single online application for health, food, child care assistance, and family planning services. These integrated eligibility systems are complex to build and maintain, but they can play an important role in assuring that vulnerable families with health needs also obtain the social supports they will require to achieve optimal health.

PROMOTING EQUITY THROUGH ACCOUNTABILITY

The drive toward accountable systems of care holds great promise for the sort of integration and coordination most important for vulnerable families. The ACA requires standardized data

collection on patients' race, ethnicity, and primary language. CHIP programs are required to collect data that includes the primary language of children, parents, and legal guardians. Yet additional efforts should be taken to promote health equity as part of “accountability” and ensure that pressure to create short-term savings does not divert attention from long-term investments in family well-being.

Eliminating Health Disparities

Comprehensive resources have been developed that describe the myriad ACA provisions that are relevant to reducing health disparities.¹¹¹ Purchasers and regulators can encourage or demand that steps be taken to reduce health disparities. A stronger evidence base can help doctors and health systems identify policies and practices that promote equity. The ACA requires nonprofit hospitals to conduct health needs assessments, develop health improvement plans, and report on how they are benefitting the communities they serve. As coverage for the previously uninsured expands under the ACA, hospitals are expected to transition from providing charity care to investing in community-building activities that focus on the social determinants of health.¹¹² All of these elements should facilitate the development, evaluation, and spread of interventions that promote equity.

Yet, the accountability movement in health care is still young, and there is much work to do to make sure it achieves its potential. Efforts to improve population health will only reduce disparities if population

health measures are examined for each racial and ethnic category and not simply aggregated for the population as a whole. The health care quality measurement enterprise is still young and has been oriented heavily toward conditions that are prevalent in the Medicare population; quality measurement for children is less well developed. Critical concepts such as care coordination are not well measured.

Pressure to Achieve Rapid Savings

Intense budgetary pressure within the Medicare and Medicaid programs has led to a desire for rapid savings. This pressure to save money yields a natural focus on secondary prevention — management of chronic diseases and reduced hospitalization and adverse events for patients with multiple chronic conditions such as diabetes and heart disease. While these are important goals, this financial model makes it challenging for the health system to invest in interventions that might yield larger and long-term sustained improvements for vulnerable families. For example, investments to reduce childhood obesity or meet the needs of the growing number of children diagnosed with autism spectrum disorders may not yield a short-term return on investment. When investments in longer-term health and well-being prevention efforts deliver savings to non-medical sectors, such as the juvenile justice or education systems, the health care system is unable to measure or capture those savings for reinvestment.

The drive for accountability can also financially disadvantage those

health care systems that serve the most vulnerable populations. Because these systems have fewer financial resources and their patients have more social barriers, they are disproportionately likely to be penalized in programs that create penalties for poor performance.¹¹³ To help address this issue, bipartisan federal legislation was recently introduced that would require Medicare to consider the socioeconomic status of patients before imposing a penalty.¹¹⁴

States, concerned with the financial burden associated with collecting and reporting data, have resisted federal mandatory quality reporting standards. The Secretary of the Department of Health and Human Services has developed core quality measures for children and adults in Medicaid and CHIP, but, by statute, reporting of those measures is optional for the states that run those programs. While 48 states and the District of Columbia reported performance on at least two child-specific measures in 2012, the median number reported across the states is just 14 out of 24 measures.¹¹⁵

Intense competition for market share within the health insurance exchange and state Medicaid program budget pressures conspire to lead participating health insurers to seek methods to hold down premiums. One method is for insurers to limit the network of participating providers to those who can offer services at a relatively low cost. While insurance plans must meet the standards of state insurance regulators, and those standards include some minimum levels of access to necessary hospitals and doctors, the standards can be minimal. As so-

One particularly important resource for states is the State Innovation Models (SIM) initiative of the Center for Medicare and Medicaid Innovation. Created in 2013, it provided funding on a competitive basis to 25 states – including four states that have declined the Medicaid expansion – seeking to modify how health care is financed and delivered to promote the Triple Aim.

called “narrow network” products proliferate, it will be important to analyze the actual access and utilization patterns of vulnerable families to be sure insurance coverage is translating into access to needed care.

Ultimately, the accountable care model will need continued refinement and improvement if it is to achieve the promise of reducing disparities and meeting the needs of vulnerable families.

CONCLUSION

The ACA moves the nation forward in expanding access to needed health care services and reorienting the health care system toward patient needs. These are critical priorities for vulnerable families, and the ACA has already brought about changes that will improve the life trajectory of many of these families. The ACA builds upon a platform of Medicaid coverage that has been a critical source of support for vulnerable families, and the Medicaid and CHIP programs, which together have cut the number of uninsured children in the U.S. by half.

The ACA places many implementation responsibilities on the states at a time when state budgets are still recovering from the 2008 recession. The significant state role in the law is a source of its

strength, but it also means progress is dependent upon decisions made in governors' offices and state houses around the country. One particularly important resource for states is the State Innovation Models (SIM) initiative of the Center for Medicare and Medicaid Innovation. Created in 2013, it provided funding on a competitive basis to 25 states — including four states that have declined the Medicaid expansion — seeking to modify how health care is financed and delivered to promote the Triple Aim. Some of the states participating in the SIM initiative are pursuing strategies specifically designed to meet the needs of vulnerable children and families. Indeed, many of the examples described in this paper are tied to the state's SIM plan. A second round of SIM funding, announced in May 2014, will provide 27 states with additional support in transforming their health care systems. This funding is an opportunity for states to better integrate care within the health system and with human services.

Health insurance coverage in the U.S. is an individual — not a family — matter. The ACA's complex coverage scheme, while providing new coverage options for many, will leave many families with different coverage for each family member. Parents may obtain coverage through the health insurance exchange, while the children are on Medicaid or CHIP. In vulnerable families, such as justice-involved families or mixed immigration status families, the parents may remain uninsured even as the children are eligible for coverage. Other circumstances — foster care, kinship care (custody by a family member other than the

parent), and incarceration — can yield different coverage for parents and children.

Even when aligned into a single program, “family” coverage is just a billing convenience. The definition of coverage, with its benefits and limitations, is always tied to an individual. Payment is made for a service delivered to an individual based on the medical necessity of treating a condition diagnosed for that individual. Illinois adopted an innovative Medicaid billing practice in 2004 that allows a mother’s postpartum depression screening to be billed to her infant’s Medicaid coverage,¹¹⁶ but this sort of family thinking in health insurance coverage is rare. As accountable care models are developed, no one is considering holding health systems accountable for family outcomes (and no data systems exist either within health care or across health and social systems that would make this possible if we wanted to do so).

The ACA has already yielded significant increases in health insurance coverage and has moved the health care system toward greater levels of accountability. But much work remains. In the area of coverage, work remains to extend eligibility to all vulnerable families, assure continuous enrollment in health insurance programs, and minimize the financial burdens on these families. When considering how care is delivered, the unfinished business includes promoting integration within the health care system, integrating human services and medical services, and assuring that accountable care models promote equity and long-term investments in family well-being.

A better functioning health system, and a health system better integrated with the human services system, is necessary to achieve a two-generation approach to creating opportunity for vulnerable families. The ACA moves the nation forward in achieving this goal, but much work remains to realize it.

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